



Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

<http://www.dmas.virginia.gov>

MEDICAID MEMO

TO: All Prescribing Providers, Pharmacists, and Managed Care Organizations (MCOs)
Participating in the Virginia Medical Assistance Program

FROM: Jennifer S. Lee, M.D., Director
Department of Medical Assistance Services (DMAS)

MEMO: Special

DATE: 9/17/18

SUBJECT: Clarification of Coverage of Medicaid Fee-for-Service Compound Drugs and
Home Intravenous Therapy-Effective September 15, 2018

The purpose of this memorandum is to inform providers about the clarification of coverage of Medicaid Fee-for-Service compound drugs and Home Intravenous therapy. — *Effective September 15, 2018*

CLARIFICATION OF COVERAGE OF COMPOUND DRUGS

Effective September 15, 2018, all topical compounded drug claims $\geq \$250.00$ and those claims with an accumulation of \$500.00 within a calendar month will deny with NCPDP error 76 – plan limitations exceeded and require a service authorization (SA). The SA will require the prescriber to document medical necessity by providing information to explain why the member requires the compounded medication. If the prescriber is using a non-FDA approved product, he/she should be able to produce documentation from the literature that supports medical necessity of the compound. Compounded medications containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) may not be covered.

HOME INTRAVENOUS THERAPY

Home Infusion Therapy: Service Day Rate

Home infusion therapy is the intravenous administration of fluids, drugs, chemical agents, or nutritional substances to members in the home setting. Medicaid has assigned a service-day-rate code and reimbursement rate for each of the covered therapies: Hydration therapy, Chemotherapy, Pain Management, Drug Therapy, and Total Parenteral Nutrition (TPN). DMAS will reimburse for these services, supplies, and drugs as described in the DMAS Durable Medical Equipment (DME) Provider Manual on the DMAS website located at <http://dmasva.dmas.virginia.gov>.

Drugs

Drugs providing the therapy's active ingredient are reimbursed according to Medicaid's payment methodology. Dispensing fees will be added to the drug cost when applicable. One dispensing fee per month per member per NDC is allowed, and the member co-pay shall be deducted if applicable. Refer to Chapter V of the *Pharmacy Provider Manual* for billing instructions that can be found on the DMAS website located at: <http://dmasva.dmas.virginia.gov>.

SERVICE AUTHORIZATION (SA) PROCESS

A message indicating that a drug requires a SA will be displayed at the point-of-sale (POS) when a prescription for a non-preferred drug is entered at point-of-sale (POS). Pharmacists should contact the member's prescribing provider to request that they initiate the SA process. Prescribers can initiate SA requests by letter, faxing to 1-800-932-6651, contacting the Magellan Clinical Call Center at 1-800-932-6648 (available 24 hours a day, seven days a week), or by using the web-based service authorization process (Web SA). Faxed and mailed SA requests will receive a response within 24 hours of receipt.

SA requests can be mailed to:

Magellan Medicaid Administration
ATTN: MAP Department/ VA Medicaid
11013 W. Broad Street, Suite 500
Glen Allen, Virginia 23060

Service authorization forms are available online at: www.virginiamedicaidpharmacyservices.com. The PDL criteria for SA purposes are also available on the same website.

MAGELLAN BEHAVIORAL HEALTH OF VIRGINIA (Behavioral Health Services Administrator)

Providers of behavioral health services may check member eligibility, claims status, check status, service limits, and service authorizations by visiting www.MagellanHealth.com/Provider. If you have any questions regarding behavioral health services, service authorization, or enrollment and credentialing as a Medicaid behavioral health service provider please contact Magellan Behavioral Health of Virginia toll free at 1-800-424-4046 or by visiting www.magellanofvirginia.com or submitting questions to VAProviderQuestions@MagellanHealth.com.

MANAGED CARE PROGRAMS

Most Medicaid individuals are enrolled in one of the Department's managed care programs: Medallion 4.0, Commonwealth Coordinated Care Plus (CCC Plus), and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 4.0:
<http://www.dmas.virginia.gov/#/med4>
- Commonwealth Coordinated Care Plus (CCC Plus):
<http://www.dmas.virginia.gov/#/cccplus>
- Program of All-Inclusive Care for the Elderly (PACE)
<http://www.dmas.virginia.gov/#/longtermprograms>

COMMONWEALTH COORDINATED CARE PLUS

Commonwealth Coordinated Care Plus is a required managed long term services and supports program for individuals who are either 65 or older or meet eligibility requirements due to a disability. The program integrates medical, behavioral health, and long term services and supports into one program and provides care coordination for members. The goal of this coordinated delivery system is to improve access, quality and efficiency. Please visit the website at: <http://www.dmas.virginia.gov/#/cccplus>

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

KEPRO PROVIDER PORTAL

Providers may access service authorization information including status via KEPRO's Provider Portal at <https://providerportal.kepro.com/Account/Login.aspx?ReturnUrl=%2f>

HELPLINE

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

TO ALL MEDICAID PROVIDERS: PROVIDER APPEAL REQUEST FORM NOW AVAILABLE

There is now a form available on the DMAS website to assist providers in filing an appeal with the DMAS Appeals Division. The link to the page is <http://www.dmas.virginia.gov/#/appealsresources> and the form can be accessed from there by clicking on, "Provider Appeal Request Form." The form is in PDF format and has fillable fields. It can either be filled out online and then printed or downloaded and saved to your business computer. It is designed to save you time and money by assisting you in supplying all of the necessary information to identify your area of concern and the basic facts associated with that concern. Once you complete the form, you can simply print it and attach any supporting documentation you wish, and send to the Appeals Division by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission supported by the Agency.

PROVIDERS: NEW MEDICARE CARDS ARE COMING

CMS is removing Social Security Numbers from Medicare cards to help fight identity theft and safeguard taxpayer dollars. In previous messages, CMS has stated that you must be ready by April 2018 for the change from the Social Security Number based Health Insurance Claim Number to the randomly generated Medicare Beneficiary Identifier (the new Medicare number). Up to now, CMS has referred to this work as the Social Security Number Removal Initiative (SSNRI). Moving forward, CMS will refer to this project as the New Medicare Card.

To help you find information quickly, CMS designed a new homepage linking you to the latest details, including how to [talk to your Medicare patients](#) about the new Medicare Card. Bookmark the [New Medicare Card](#) homepage and [Provider](#) webpage, and visit often, so you have the information you need to be ready by April 1st.

Providers (which includes fee for service, Medicaid Managed Care Organizations, and Commonwealth Coordinated Care Plus) may share the following information with members:

MEMBERS: NEW MEDICARE CARDS ARE COMING

Medicare will mail new Medicare cards between April 2018 and April 2019. Your new card will have a new Medicare Number that is unique to you, instead of your Social Security Number. This will help to protect your identity.

Additional information is available at the following link:

<https://www.medicare.gov/forms-help-and-resources/your-medicare-card.html>
